The Medical Review Division's Findings and Decision of September 16, 2003, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.

This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 10/01/02.

I. DISPUTE

Whether there should be additional reimbursement for the date of service 01/09/02.

II. RATIONALE

The requestor submitted an EOB with the denial code of "M-No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area. N-Not appropriately documented." Ambulatory Surgical Center care is not covered by the *Medical Fee Guideline* and shall be reimbursed at a fair and reasonable rate per Commission Rule 134.401 (a)(4).

The respondent submitted an EOB with the denial of "N". The requestor submitted an operative report that carpal tunnel release was performed and services were rendered. Therefore, the documentation submitted satisfies this denial code of "N".

The respondent asserts in their position statement that they have paid a fair and reasonable reimbursement based on inpatient hospital stay and Medicare based payments. However, other than SOAH decisions evidence of other payment samples including Medicare was not provided to support fair and reasonable payment per §413.011. Documentation submitted by Textron does not support that the charges are for similar treatment in the same geographical area to an injured individual of an equivalent standard of living.

The requestor billed $4,393.43 for the Ambulatory Surgical Center care; the respondent reimbursed $946.88 leaving a balance of $3,446.55. Rule 133.307(g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable.

The requestor submitted redacted EOBs that indicate that they have accepted reimbursements for similar treatment in the same geographical area to an injured individual of an equivalent standard of living, at 100% of their billed charges. However, requestor's position indicates the average workers' comp reimbursement is 84%. This is the typical, most dominant payment received and the lesser of what is acceptable as fair and reasonable to the Requestor. On this basis reimbursement is recommended at 84% of billed charges less the amount paid. ($4,393.43 x 84% = $3,690.48 - $946.88 already paid = $2,743.60 for additional reimbursement).

III. AMENDED DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to additional reimbursement for Ambulatory Surgical Care in the amount of **$2,743.60.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$2,743.60** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Amended Findings & Decision is hereby issued this 15th day of October 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/mb